HEALTH INFORMATION TECHNOLOGY BLUE RIBBON TASK FORCE
DRAFT MEETING MINUTES

February 12, 2010
9:00 am

Legislative Building
401 South Carson Street, Room 2134
Carson City, NV 89701-4747

Grant Sawyer State Office Building
555 East Washington Avenue, Room 4401
Las Vegas, NV 89101-1072

TASK FORCE MEMBERS PRESENT:

Carson City:
Peggy Brown
Tom Chase
Robert "Rob" Dornberger
Rick Hsu
Scott Kipper
Stephen Loos, MD

Las Vegas:
Dr. Raymond Rawson, Chairman
Marc Bennett, Vice Chairman
Bobbette Bond
Chris Bosse
Brian Brannman
Valerie Rosalin, RN
Robert "Bob" Schaich
Glenn Trowbridge

TASK FORCE MEMBERS EXCUSED:

Tracey Green, MD
Charles "Chuck" Duarte
Marena Works, RN

DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) STAFF PRESENT:

Lynn O'Mara, Health Information Technology Project Manager, Director's Office, DHHS
Cynthia Pyzel, Assistant Chief, Bureau of Public Affairs, Office of the Attorney General
Mel Rosenberg, Chief of IT, Nevada Division of Healthcare Financing & Policy
Ernesto "Ernie" Hernandez, IT Manager III, Office of Informatics and Technology, Health Division
Theresa Presley, IT Professional II, Office of Informatics and Technology, Health Division
Joyce Miller, Administrative Assistant, Director's Office, DHHS

OTHERS PRESENT:

Caroline Ford, M.P.H, UNSOM and Director**,** Nevada Office of Rural Health
Deborah Huber, RN**,** HealthInsight
Charles Harvey, ARRA Director, Office of the Governor
Dennis Freimann, ARRA Management Analyst, Office of the Governor
Erin McMullen, Attorney, Snell & Wilmer
Jack Kim, United Healthcare Nevada
Jim Andres, Connected Nation
Jonathan Snyder, President, Chief Executive Officer and Director, KeyOn Communications
Kathleen Conaboy**,** Executive Director, Nevada Orthopaedic Society
Larry Hurst, Anthem Blue Cross Blue Shield
Leslie Johnstone, Health Services Coalition
Merlinda Gallegos, Community Development Coordinator, Arizona Nevada Tower Corporation (ANTC)
Mike Pieper, Executive Vice President, R&R Partners
Russell Suzuki, Vice President, Health Information Management Systems Society (H*i*MSS®) - NV Chapter

Dr. Raymond Rawson, Chairman, called the meeting to order at 9:00 a.m. He stated that today's meeting agenda was posted in accordance with Nevada Open Meeting Law at the Nevada Department of Health and Human Services, the Grant Sawyer State Office Building, the Legislative Building, the Nevada State Library and Archives, and on the Nevada Department of Health and Human Services web site. He also explained that the meeting was being videoconferenced from the Legislative Building to the Grant Sawyer Building, as well as being broadcast live over the Internet.

Dr. Rawson stated that public comment would be taken later during the meeting. He reminded everyone that when speaking to state their name and who they represented, for the record. Also, he commented that as the Chairman, he reserved the right to limit comments to three (3) minutes per person, and would respectfully interrupt if the time was exceeded. In addition, he asked that information already presented by someone else not be repeated.

Dr. Rawson reminded everyone in Carson City and Las Vegas to please sign the attendance sheet for their location, and then directed Joyce Miller to call the roll.

1. Roll Call and Approval of Meeting Minutes from the January 8, 2010 meeting

Joyce Miller called the roll. She informed the Chairman that Chuck Duarte was excused, Mel Rosenberg would represent him. Ms. Miller also informed the Chairman that Dr. Green was excused, and Ernie Hernandez would represent her.

Ms. Miller informed Dr. Rawson that a quorum was present.

Dr. Rawson asked the Task Force members if there were any additions or corrections to the minutes of the January 8, 2010 meeting. There being none, he asked for a motion to approve the minutes.

MOTION: Bob Schaich moved to approve the minutes from the January 8, 2010 meeting.
SECOND: Glenn Trowbridge
APPROVED: UNANIMOUSLY

2. Introductory Remarks

Dr. Rawson referred to Agenda Items 3 and 4 and stated that Lynn O'Mara had some announcements for the members, followed by a status report on the State HIE Cooperative Agreement grant.

3. Announcements and Future Meeting Schedule

Ms. O'Mara reviewed the contents of the Task Force Members packet. She informed the members that that the majority of the documents were informational and follow-up documents from the last meeting, as well as some additional information requested by some of the Task Force Members. Ms. O'Mara also referred the members to the suggested schedule of Task Force meetings for the remainder of the calendar year. She proposed that the meetings be moved from the second Friday of the month to the third Friday, to avoid further conflicts is with the State Board of Health meeting schedule. None of the Task Force members cited any problem with moving the meetings.

Dr. Rawson mentioned that December 17, 2010 would be a busy time of the year, and asked the Task Force if there were any concerns with that date. None were cited. He directed Ms. O'Mara to proceed with getting the meetings scheduled as proposed and commented that the December meeting date would be reviewed in the fall.

4. Staff Report: State Health Information Exchange Cooperative Agreement

Ms. O'Mara referred the Task Force to their meeting packet. She explained that the document entitled "HIT/HIE Timelines" was prepared at the request of the Task Force during the January meeting. The table compared the various ARRA grants and cooperative agreements that would impact HIT and HIE. She informed the Task Force that Mr. Bennett has received notification just prior to the start of the meeting that the funding announcements for the state HIE Cooperative Agreements and for the HIT

Regional Extension Centers grants had been made by federal HHS. Nevada did receive the expected funding amount quoted back in October, and HealthInsight was designated as the HIT Regional Extension Center for Nevada and Utah. Ms. O'Mara stated that she would provide more detailed information during the March meeting, after she had the opportunity to review the funding announcement package in its entirety. She commented that some of the HIE Cooperative Agreement deadlines could change. Ms. O'Mara reported that inquiries were being made regarding pooling the state and Medicaid HIE grants to do the environmental scan, and hoped to have an answer in time for the next meeting. She also directed attention to the Electric Health Record (EHR) Beacon Cooperative Agreement, on the Timelines document. Ms. O'Mara informed the Task Force that Renown Health had submitted an application for this funding; explaining that it was focused on community-wide EHR adoption and only fifteen grants would be awarded. She then asked Ms. Bosse to provide more information to the members about the Beacon grant.

Ms. Bosse explained that the Beacon grant's primary objective is to demonstrate that with meaningful use of EHRs within a community, there would be improvements in health care quality, outcomes and cost effectiveness. She stated that Renown had applied to be the lead organization for their community, as it already had an EHR system in place. Ms. Bosse mentioned that Mr. Bennett probably has a similar story for Utah, who also submitted an application. Beacon grant funding announcements were expected by end of March.

At 9:15 am, Ms. O'Mara informed the Chairman that Ms. Bond and Mr. Brannman were now present.

Ms. O'Mara provided an update regarding EHR "meaningful use" for hospitals and providers, directing the members to the summary information provided in their packets, courtesy of Mr. Duarte and the National Association of State Medicaid Directors. Proposed criteria and interim regulations had been released by CMS and ONC in late December 2009, and public comment would be taken until March 15, 2010. She noted that there were links on the DHHS HIT Web site to the related federal Web sites. Ms. O'Mara noted that she hoped to complete a risk or gap analysis of the impact of meaningful use on HIE requirements by the next meeting, and it would be useful for the upcoming HIE strategic planning process.

Ms. O'Mara referenced the presentation provided to the Task Force by Brad Tritle during the January meeting. She reported that Mr. Tritle had agreed to provide some additional information to the members, and it was included in the packet for this meeting. In addition, there was some additional information included that Ms. O'Mara had found that she believed would be helpful to the Task Force.

Ms. O'Mara informed the Task Force that Todd Radtke, the Broadband Task Force Chairman, had reported that Nevada did not receive any broadband funding during the first round of grant awards. The Broadband Task Force is doing all it can to reach out to the industry and suggest more partnerships for the second and final round of broadband grant funding.

Ms. O'Mara commented that regional Work Force Development application was submitted and Nevada was an included partner. Unfortunately, Dr. Trevisan was not present to provide a more detailed update. At the request of Task Force members, Dr. Trevisan and Caroline Ford, from the School of Medicine, are scheduled to provide more information on the work force issues mentioned during previous meetings, during the March 12, 2010 meeting.

Ms. O'Mara reported that she had researched some information provided by the Nevada ACLU during the January meeting, regarding the lack of support by the Patient Privacy Rights (PPR) Foundation (www.patientprivacyrights.org) for health record banks. She contacted Dr. Yasnoff, and he confirmed that he has been working for some time with the PPR at a national level. While the group has not endorsed any particular HIE model or option, it does support the level of privacy proposed by the bank model.

Ms. Bond asked if there was anything that could be done by the Task Force to help with issues and concerns facing the Broadband Task Force and getting grant applications submitted that resulted in successful funding awards. Ms. O'Mara replied that she would communicate that to Mr. Radtke, when she met him later in the month, and report back to this Task Force.

5. Discussion: Information Previously Presented

Dr. Rawson reported that Task Force Members requested time for further discussion regarding some of the information presented during previous meetings. He asked if there were any questions or if anyone wanted to lead the discussion.

Mr. Bennett commented there were a number of decisions which would need to be made. He then outlined the six issues he believed the Task Force would need to discuss in depth and take action on. The issues, based on the state HIE Cooperative agreement requirements, are:

1. HIE Governance Model: Would it use Nevada Medicaid's HIE as the core and expand it for statewide use? Would a non-profit model best serve Nevada? Would a community board be organized to establish and run the HIE? Would we let the market come forward with an entity that would establish a public-private partnership to build the HIE together?
2. Geographic Issues: Is a statewide HIE the best option? Does Nevada need a Clark County HIE, a northern Nevada HIE, a rural HIE, or some combination to accomplish statewide HIE?
3. Data Issues: Will the HIE use a distributed data model? Would organizing the data into a central database be best?
4. Privacy and Security Issues: Ultimately, it seems to come down to two choices: "opt in" or "opt out". Will the EHRs of Nevada residents automatically be part of the HIE, unless they said they did not want them to be, or vice-versa? Both would need to be considered, although it would add complexity to ask each individual if they wanted their data to be included. It may be simpler include everyone and allow them to decide not to have their data included.
5. Funding for the HIE: Will a voluntary funding model be feasible, data users pay transaction or some other kind of fees? Would e-options be better, where they are attached to health insurance claims? Also, sustainable funding for the HIE will need to be determined, for ongoing HIE operations.
6. Policy Issues: What kind of legislation may be required? Would the Governor have to authorize the legislative requests? Will mandates be necessary, or will the stakeholders cooperate, if enabling legislation only encourages participation?

Dr. Rawson commented that if mandates were recommended, they would have to be specific, with the necessary justification. Mr. Bennett stated that the issues he outlined were a starting point and that the list would probably grow as the Task Force got farther through the planning and implementation phases. Ms. O'Mara noted that the Nevada HIE Cooperative Agreement required that all these issues be addressed in either the Strategic Plan or Operational Plan.

Mr. Hsu noted that there needed to be discussion of the issues brought up by Mr. Bennett, and offered some opinion regarding an overlap of three important issues: the Governance model, the funding mechanisms, and the method of data distribution, i.e., a federated model vs. a centralized model. He stated that while had no background in health care, as an outsider, it seemed to him that the presentation from Dr. Yasnoff was compelling regarding the pros and cons of the federated model vs. the centralized model. Mr. Hsu commented that the decentralized approach of the federated model would mean that it would take "forever" to gather the patient's information. He believed that the single data location or source offered by the centralized model would better support the need for "airtight" privacy, as there would be only one location requiring security and control. Mr. Hsu referred to the January presentation by Arizona, who had tried the federated model, found it did not work for the state, and was considering a centralized model similar to what Dr. Yasnoff had presented. He stated that he believed Nevada would benefit from these kinds of lessons, so that Nevada could use its resources to its best advantage. Mr. Hsu commented on how he believed the funding of a centralized model could be accomplished, and encouraged the Task Force to explore various options for creating external funding sources. He

referenced Google, noting that it may not be the best example. Mr. Hsu referenced the Google business model, which relies on external funding sources such as advertising premiums and "per Click through" fees, along with sophisticated database searches and data mining, to be profitable. He stated that from his standpoint, as an outsider, he again believed that a centralized model would be better, and that potential external funding sources needed to be explored. Mr. Hsu noted that if Dr. Yasnoff was correct, the incentives were there to support the centralized model. He commented most individuals pay cell phone charges of $80 to $100 per month, and would probably be willing to $20 per year for centralized digital storage of their health care records. The pricing level seemed low enough, with the right incentives.

Dr. Rawson stated that whatever governance model was adopted needed to result from thorough discussion. He stressed that many of the decisions that would need to be made would potentially impact people's lives and budgets, and, therefore, proper vetting was required.

Ms. Bond requested that a table or grid of Mr. Bennett's decision points, cross-walked with known options, might be useful to the Task Force. She remarked that it would help the members to distill and prioritize the issues for discussion and recommendations.

Dr. Rawson suggested a packet of briefing papers might be helpful when working with stakeholders and groups external to the Task Force. Mr. Bennett agreed, as it would be important to distinguish options that may not yet be proven to from those that had already been implemented, and to better examine the strengths and challenges presented by the various alternatives. Dr. Rawson commented that the model eventually selected would have to be feasible and practical.

Ms. Bond commented that, in the beginning, Ms. O'Mara had attempted to take into consideration where Nevada was with respect to the decision point areas Mr. Bennett had outlined, and believed the Task Force needed to return to that perspective. She noted that the various health care groups were typically leery of embracing something new, especially if no useful track record existed. Ms. Bond stated her belief that it was important for the Task Force to at least back something, since as a cohesive leadership group, it ought to be able to move in one direction. This was particularly important given the state's current environment and economic situation, the way healthcare is disbursed, the geographic centers and the work already done by other coalitions and organizations. She suggested that a model needed to be developed, to serve as a blueprint for moving things forward. While the model did not have to be perfect, it did have to be manageable. Dr. Rawson agreed that the need was there and there were benefits to being the leader.

Ms. O'Mara reported that Nevada was invited to join a multi-state collaborative that Arizona was considering, regarding health record bank. Washington state currently has three pilot projects in process, Louisville, Kentucky has already started a bank, and Phoenix was considering starting a pilot bank in the six months. The Arizona Governor's Office was in favor of the collaboration, and initial feedback from ONC was positive for pooling resources in this way. Ms. O'Mara will keep the Task Force updated on how this idea evolves.

Mr. Chase commented he believed Mr. Bennett's list was very comprehensive, and requested that one more area be added. He would like to have minimum requirements established for HIE speed and availability, as availability was a substantial part of the argument for the banking model. Mr. Chase cited various scenarios, regarding potential data needs that would impact data accessibility and availability requirements, as well as the value of urgency. He also cited the need to determine expected outcomes at the clinical level and what would be needed to achieve them.

Mr. Bennett stated that he believed that in his presentation, Dr. Yasnoff provided a biased view of the operational effectiveness of the federated model. He explained that he believed large sophisticated health care provider groups, hospital systems and insurance plans had the ability safeguard data in a superior way to a health record bank. Mr. Bennett commented that he believed there fifteen or more currently operating HIEs using the federated model and employing edge servers that worked just fine. He cited the greatest need was for basic continuity of care information about a patient's current medications and lab

results, and not the ability to move every piece of information and to move it quickly. Mr. Bennett referenced Grand Junction, Colorado and several other communities around the country which have successfully achieved the same kind of information flow without building a centralized database. He reiterated his perspective that Dr. Yasnoff presented an academic view of what would be theoretically perfect.

Dr. Loos agreed that it was important to question the timeliness of when information could be obtained, especially by a hospital emergency department. He stated his belief that the working models cited by Mr. Bennett have probably not been tracking those kinds of times or how quickly that information moves around. Dr. Loos commented that the sooner a treating physician received the information, the better the outcome for the patient. Therefore, if that was a limitation of the federated model, then it would be an issue. He referred to Dr. Yasnoff's presentation, stating that it was compelling from the standpoint of the banking concept itself and the fact that it was patient-centered, which is a current trend in health care. Dr. Loos noted that in today's health care culture, most individuals want to take charge of their own health care, including their personal health information, and the bank concept addresses those privacy issues where the patients consent to have their data moved around. He stated liking the simplicity of the bank concept, and understood the federated model and its strategy. Dr. Loos said that what Dr. Yasnoff presented was something more tangible in terms of better understanding how it would work in a health care system. He also liked the physician incentives that Dr. Yasnoff discussed, as the most important thing right now was getting everyone using EHRs, otherwise HIE wouldn't happen. Therefore, providing physician incentives to adopt EHRs is important. Dr. Loos asked Mr. Bennett if these systems were mutually exclusive or if they were competitive. He stated that it seemed like they were, and wanted to understand that as well.

Mr. Bennett replied that he did not know if they were mutually exclusive, and stated that he believed the proposed centralized health-banking model was a twenty-year plan. He explained that the level of critical mass that Dr. Yasnoff referenced would require existing practices and systems that were more advanced, which already had large databases of information to either give that information up and convert their existing systems to tap into the centralized bank for that type of data or to build an individual interface. The bank would require the market to work so that every medical practice or a majority of practices in the system all wanted the information to be housed in central data bank. Mr. Bennett stated that the twenty-year timeframe could be accelerated if everyone was mandated to use a bank. At the state level, it may mean legislating that everyone receiving health care services in Nevada would be required to store their health information in a bank. Short of that type of centralized action, he believed it would be a very long-term vision as to where one could get to. Mr. Bennett clarified that the federated model had the advantage of being able to operate within a year or eighteen months, allowing major systems in a community to exchange information and had a master patient index so that individuals in small practices with an EHR could also access information. Most federated models in operation had a stepping process to bring providers on who do not have an EHR. Therefore, he believed that the federated model was more sensitive to the realities faced at a state level. Mr. Bennett again referenced the Grand Junction model, commenting that nit was used routinely in emergency departments and each of the providers, either through a centralized service that used an edge server or through their own edge server, basically has a version of their own data available. These are near real-time tools and it is not technologically difficult to make the information available immediately. The greater challenge with any model was the accompanying politics. He explained that stakeholders would have to agree to work together, which he believed was a major challenge of Dr. Yasnoff's model.

Mr. Rosenberg commented on the potential impact of interstate HIE and interoperability between systems or models, citing possible scenarios. Dr. Rawson again stated that more in depth review and discussion would be required.

6. Discussion: Task Force Report to the Governor due April 30, 2010

Dr. Rawson asked Ms. O'Mara to provide a brief explanation of the preliminary report that is due to the Governor's Office.

Ms. O'Mara reminded the Task Force that there is a report due to the Governor's Office by April 30, 2010 regarding HIE legal and policy recommendations. She explained that the Governor's Office would need to know what Bill Draft Requests, or BDRs, it would need to designate for requesting HIE legislation, during the upcoming 2011 Legislative Session. Ms. O'Mara referred back to the memo from the Nevada ACLU provided to the Task Force during its January meeting, commenting that the list of questions posed was a good starting point for the issues that would need to be addressed for the HIE Cooperative Agreement Strategic and Operational Plans.

Mr. Rawson directed that when there are action items like these, the agenda ought to list them item by item, for proper discussion and decision making.

Ms. O'Mara reported that she had started a very preliminary legal inventory. Within the Nevada Revised Statutes, or NRS, there were four full titles that would require review and possible amendments, along with approximately a half dozen individual chapters. She stated that while the HITECH Act added new HIPAA provisions for EHRs, the Federal Trade Commission (FTC) had jurisdiction over PHRs, and those laws would also have to be reviewed as part of a full legal inventory. Ms. O'Mara informed the Task Force that NRS Title 59 covered Electronic Records and Transactions, although there were no chapters specific to EHRs or privacy protections. It is possible that a new chapter or two would need to be created and added under that title, to cover some of the specific HIE legislation that would be necessary. She reminded the Task Force that as discussed during the January meeting, it was probable that not everything would be covered during the 2011 session. There would be many unknown variables that probably would not surface until full HIE implementation occurred, requiring more legislation during the 2013 session. Ms. O'Mara said she hoped to have a rough report draft for the Task Force to review during its March meeting, with a final draft being presented during the upcoming April meeting.

Ms. O'Mara reported that the National Conference of State Legislatures had recently established an online searchable database of proposed and enacted HIT/HIE legislation, by state. She commented that her peers had suggested reviewing the recent HIE legislation enacted by New Mexico, as it was fairly comprehensive and a good starting point.

Ms. Bond asked Ms. O'Mara if for the next meeting the members needed to be prepared to contribute draft language for the bill drafts. Ms. O'Mara stated that feedback from the members regarding policy issues might be requested. She reminded the Task Force that the HIE Cooperative Agreement required five specific domains be addressed in the strategic plan, one of which included a legal inventory. Ms. O'Mara anticipated that the draft report will recommend the BDRs the Task Force believes will be necessary, along with the required preambles, to meet the May BDR deadline of the Department of Administration. As part of the strategic planning process, the Task Force could draft the actual language and/or key points to be included in the requested bill drafts, and still meet the September LCB deadline for Executive Branch BDRs.

Ms. Bond asked if they would have a "second bite of that apple", as the strategic planning process would most likely result in additional issues that would need to be addressed. Dr. Rawson commented that the Task Force would probably need several reviews of the policy issues, as there were many unknowns that would be identified by the planning process.

Dr. Rawson reminded the Task Force that Open Meeting Law members to discuss the issues among themselves or in small groups; provided a quorum was not present. He stated that the goal was to have a well thought out and vetted plan, with significant contributions by the members. Just "rubber stamping" a plan without any serious work done by the Task Force was not acceptable

Mr. Hsu inquired what types of topics were being contemplated for the BDRs. Dr. Rawson stated that one area already identified was the privacy issues raised by ACLU Nevada. These would have to be cross-walked with existing state law to determine what a related BDR would have to address, along with the compelling argument to change existing law. Dr. Rawson commented that broad scope HIE proposals and plans could result in roadblocks by existing legislation. He encouraged the members and staff to take

that into consideration as the planning process moved forward. He reminded the members that existing law was the result of well reasoned discussions by the Legislature, and changing existing law was not a matter to be taken lightly. It was an arduous process, and well crafted BDRs that were the result of factual information and sound deliberation would ensure that necessary legislation would be seriously considered by the Legislature.

Ms. O'Mara commented that the National Governor's Association had recently released a report regarding interstate HIE, and enabling legislation may be required. She stated that enabling legislation for HIE in general might be required, as several states found and had to pass the necessary laws. Dr. Rawson noted that determining the governance model will be the first step in that process.

7. Public Comment and Discussion

Dr. Rawson asked if there was any public comment.

Jonathan Snyder introduced himself as the CEO for CAM Communications, a broadband provider in rural and underserved markets throughout the United States. Mr. Snyder stated that his company had been a Nevada applicant for the first round of broadband stimulus funds and had invested a fair amount of capital fair to build broadband infrastructure throughout the state, particularly the underserved rural areas, through the Department of Agriculture of Rural Utility Service Broadband Initiatives Program. He addressed Ms. Bond's question regarding assistance for broadband grant applications, and explained that they are a private enterprise and are still in the process of coming through round one due diligence and although do not know what the outcome will be, CAM Communications had begun to interface directly with the Nevada Broadband Task Force in the state. Mr. Snyder continued that CAM is working with the Rural Utility Service in Nevada, and as a private enterprise, his company is working to collaborate with various entities to foster HIT in Nevada, particularly as a rural services operator to be provide broadband He commented that Nevada is one of eleven states that CAM is working with. Dr. Rawson asked Mr. Snyder to communicate with this Task Force regarding any support that CAM may require, related to broadband and HIE. Mr. Snyder commented that CAM was also working with the National Coalition for Health Information.

Mike Pieper, with R & R Partners, stated that his firm has been working with several members of this Task Force – UMC, Renown and the Nevada Hospital Association – to develop a round two broadband application to create a statewide tele-health network. This plan has been in the works for several months, and he wanted to make the Task Force aware this effort. He reported that the intention is to create a network that could be used to support an HIE between the hospitals and the state. In addition, a key challenge will be EHR adoption by certain large and small hospitals in the state that do not have the financial resources required for EHR adoption, beyond the CMS incentives. Mr. Pieper concluded his comments by offering a presentation to this Task Force, at one of its future meetings, regarding the network being proposed for the broadband grant. Dr. Rawson directed Mr. Pieper to work with Ms. O'Mara, for a future agenda presentation.

Dr. Rawson commented that it was important to ensure that the rural areas, especially the rural hospitals, were included in the HIE process. Mr. Pieper commented that R&R has been working with Todd Radtke and Nevada Rural Health Partners on that very issue. He commented that while the ARRA HITECH Act included a provision authorizing an EHR adoption loan program, which would provide a $5 federal match for each state dollar used to create a program, the loan program had yet to be funded at a federal level. If it were to be funded, it would require Nevada to establish its own program, in order to take advantage of the federal dollars. Given the state's current financial situation that may not be possible.

Merlinda Gallegos, with the Arizona Nevada Tower Corporation commented that her company was planning to submit an application for a UDSA Rural Utilities Services Broadband Initiative Program round two grant, with the focus on rural outreach past Yerington. She requested the opportunity to return and share ANTC's plans with this Task Force, and Dr. Rawson directed her to coordinate with Ms. O'Mara.

Russell Suzuki, from the Nevada Chapter of the Health Information Management Systems Society (H*i*MSS®), explained that national and chapter activities include informing and educating about healthcare IT issues. Locally, the chapter is working in coordination with MGM, the Clark County Medical Society and the Southern Nevada Medical Industry Coalition (SNMIC) on the Nevada EHR initiative, which is educating local physicians on issues pertinent to them for EHR adoption, including best practices. Mr. Suzuki mentioned that on February 25, 2010, the SNMIC was sponsoring a vendor showcase. Dr. Rawson asked if this showcase was exclusively for his group, and Mr. Suzuki explained that it was open to anyone. Dr. Rawson asked that the Task Force receive information for those on the Task Force who would like to participate, and Mr. Suzuki stated that he would send the information.

Ms. Bond asked Mr. Suzuki if he could provide any information regarding how provider EHR adoption was going.

Mr. Suzuki replied that most physicians were making it a priority in 2010, in order to be eligible for the EHR "meaningful use" incentives beginning in 2011. He then disclosed that he is the CEO of two EHR-related companies. Falcon Technology provides hardware for various EHRs, and Certified Healthcare Systems is the Nevada certified reseller for Allscripts™.

Dr. Rawson asked if there were any other public comments. There were none. He reminded the Task Force that the next meeting was scheduled for March 12, 2010.

8. Adjournment

At 10:20 a.m., Dr. Rawson thanked the Task Force members for their participation and adjourned the meeting, stating he did so in memory of Marie Saldo, to honor her and show respect for the many years she spent helping to design major healthcare systems in the state and for her tireless efforts working with the Legislature.

Arizona Nevada Tower Corp.

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Las Vegas, Nevada 89119
702-454-2682/ 702-983-2665 Fax

Arizona Nevada Tower Corp. (ANTC), incorporated in February 2003, is an existing wireless communication service and infrastructure business based in Las Vegas, Nevada with strong ties throughout the state. ANTC specializes in providing wireless communications facilities in strategic locations throughout Nevada, including an existing network servicing 850 miles of the U.S. Highway 95 and U.S. Highway 93 NAFTA corridors leading out of Las Vegas.

ANTC has expanded its operations by focusing on providing carrier grade backhaul service throughout its growing network, and by providing wireless broadband Internet access to select rural communities through collaboration with the U.S. Department of Agriculture's (USDA) Rural Utilities Service (RUS). ANTC is dedicated to bringing redundant and reliable broadband data access to underserved communities throughout Nevada by partnering with local anchor institutions (e.g. medical and healthcare providers, public safety entities, libraries, K-12 schools, community colleges and other institutions of higher education, and other community support organizations).

ANTC is currently applying for a RUS Broadband Initiatives Program (BIP) loan/grant. An award under the RUS BIP program will allow ANTC to further develop infrastructure that will fuel long-term economic growth and opportunity throughout rural Nevada. Following are some of the communities that will benefit from this partnership:

- Duckwater
- Currant
- Austin
- Carvers
- Hadley
- Manhattan
- Yomba Reservation
- Schurz
- Fernley
- Yerington & Yerington Colony
- Dayton
- Silver Springs
- Fallon
- Weed Heights
- Mason
- Smith Valley
- Dyer
- Fish Lake Valley
- Tonopah

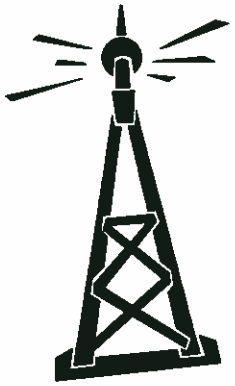
While ensuring a seamless carrier coverage footprint in an ever growing network, ANTC is committed to being a responsible corporate citizen. ANTC is committed to rectifying the technological inequities in underserved areas by offering new or substantially upgraded services to anchor institutions which compose the safety net of every community. ANTC is steadfast in its mission to connect these essential organizations in rural Nevada to broadband services; economic development will be bolstered, and overall quality of life will be enhanced.

Arizona Nevada
Tower Corporation

Nevada Community Anchor Wireless Backhaul Solution

Kevin Hayes, Vice President

Who is ANTC?



1. Rural Nevada Tower Developer

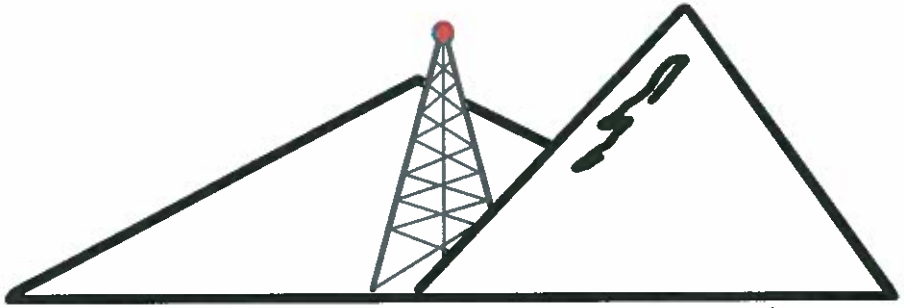
2. Broadband Backhaul Provider

3. Rural WISP

ANTC & A.R.R.A.(USDA BIP)

- ANTC's design provides high speed access to more than 20 communities including 4 tribal communities.
- Hospital/Clinic access in communities where fiber is either at capacity or nonexistent.
- Significant cost savings for wholesale transport to all users
- Allows for expanded communications capabilities across the board

Nevada Coverage Map



QUESTIONS

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Nevada Health Information Technology Blue Ribbon Task Force
HIE Planning Subcommittees

Framework for Meetings
April 9, 2010

1. Meetings will be held via conference calls, in accordance with Nevada Open Meeting Law, and conference call services have been arranged. Meetings* can begin as soon as possible, as long as Open Meeting Law requirements can be met. Subcommittees are subject to all Task Force bylaws.

2. Subcommittee objectives are based directly on the State HIE Cooperative Agreement Requirements, Terms and Conditions expected of all recipients. The State HIT Coordinator will provide more specific information to each Subcommittee, regarding what is necessary for the strategic plan and what is necessary for the operational plan.

3. Subcommittee Chairs are responsible for setting meeting agendas and working with DHHS staff to get the agendas written, posted and distributed. Agendas must be posted by 9:00 am, three full days before the actual meeting date. For example, a meeting to be held at 11:00 am on May 21, would have to be posted by 9:00 am on May 18. Task Force members will be notified of all Subcommittee meetings.

4. DHHS staff will support the work of the Subcommittees: arranging the conference calls, posting and distributing agendas, recording the meetings, drafting meeting minutes, assisting with the preparation of the final reports, and making sure that the DHHS Web site is kept updated with Subcommittee information and meeting materials.

5. To assist them with deliberations, Subcommittees can call on subject matter experts, stakeholders, coalitions, Task Force members, and other Subcommittees.

6. Subcommittees may elect Vice Chairs, and Chairs may assign tasks to the members. Members may work together outside of meetings, as long as a quorum is not present.

7. Subcommittees are encouraged to coordinate their efforts and work together, where there are similar or overlapping issues and to maximize the exchange and discussion of ideas. To help facilitate this process, each Subcommittee Chairs will provide an Interim Progress report to the full Task Force during the May 7, 2010 meeting. The reports do not have to be formal or written. Please include how the Subcommittee intends to proceed, share preliminary thoughts/ideas, and report progress to date.

* There are certain dates when Subcommittee meetings will not be possible, due to DHHS staff unavailability (HIT Task Force meetings, required state/federal meetings, and furlough days). Right now, these dates are:

April 16	May 6-7
April 20-21	May 10-14
April 26-27	June 10-11
April 29-30	June 18

Nevada Health Information Technology Blue Ribbon Task Force
Proposed HIE Planning Subcommittees
April 9, 2010

Task Force Members in **BOLD**

Subcommittee on HIE Technical Infrastructure
Dr. Stephen Loos - Chair
Brian Brannman
Robert Schaich
Alicia Hansen (DHHS)
Ernie Hernandez (DHHS)
Todd Radtke – (Nevada Rural Hospital Partners)
Mel Rosenberg (Nevada Medicaid)

Objectives: Recommend a statewide HIE technical infrastructure that 1). leverages existing efforts, resources and assets; 2). facilitates shared directories and technical services; 3). ensures intra-state, interstate and nationwide HIE, including the NHIN; 4). enables telemedicine integration into EHRs; 5). is integrated, scalable and technically sustainable; 6). meets interoperability standards and requirements; and 7). supports HIE services, including:

- Electronic eligibility and claims transactions,
- Electronic prescribing and refill requests,
- Electronic clinical laboratory ordering and results delivery,
- Electronic public health reporting (e.g., immunizations, reportable laboratory results, population health, etc.),
- Quality reporting,
- Health economics analysis,
- Prescription fill status and/or medication history, and
- Clinical summary exchange for care coordination and patient engagement.

Interim Progress Report due May 7, 2010
Final Report and Recommendations due June 11, 2010

Subcommittee on HIE Governance and Accountability
Bobbette Bond - Chair
Chuck Duarte
Rick Hsu
Scott Kipper
Deborah Huber (HealthInsight)
Dr. Gregory Mosier (Dean, UNR College of Business)
Bill Welch (Nevada Hospital Association)

Objectives: Recommended a statewide HIE governance structure that 1). enables statewide HIE for health care stakeholder groups, including providers, payers and pertinent government agencies via a State Designated Entity (SDE); 2). facilitates coverage of all providers for meeting

HIE and meaningful use requirements; 3). ensures the coordination, integration and alignment of efforts with Medicaid, public health (e.g., immunization registry, communicable disease reporting, epidemiological surveillance, etc.), federal health delivery systems (e.g., IHS, VA, DoD, etc.), and state health insurance exchanges; 4). protects personal health information in a secure manner; 5). establishes mechanisms to provide oversight and accountability of HIE to protect the public interest and ensures HIE among providers are compliance with applicable policies and laws; 6). creates new private sector business and job opportunities, and 7)enables health economics analysis and evaluation.

Interim Progress Report due May 7, 2010
Final Report and Recommendations due June 11, 2010

Subcommittee on HIE Financial Viability and Sustainability
Chris Bosse - Chair
Robert Dornberger
Tom Chase
Leslie Johnstone (Health Services Coalition)
Steve Boline - (Nevada Rural Hospital Partners)
Jack Kim (United Health Group and Nevada Association of Health Plans)
Dr. Jeanne Wendel (UNR Health Economics Professor)

Objectives: Identify feasible public and/or private financing mechanisms for funding the required federal matches for HIE grants, the HIE SDE, and EHR adoption, and make recommendations on which mechanism(s) would be the best path to a sustainable HIE.

Interim Progress Report due May 7, 2010
Final Report and Recommendations due June 11, 2010

Subcommittee on EHR Adoption and Meaningful Use
Marc Bennett – Chair
Dr. Tracey Green
Dr. Maurizio Trevisan
Caroline Ford (UNSOM and Office of Rural Health)
Justin Luna (Nevada Medicaid)
Larry Matheis (Nevada State Medical Association)
Keith Parker (HealthInsight)

Objectives: 1). Identify barriers to EHR adoption and potential strategies to remove the barriers. 2). Recommend standards for HIE data transmission and aggregation that support clinical care standards and meaningful use. 3). Identify workforce readiness requirements and recommend strategies and/or programs to meet workforce needs.

Interim Progress Reports due May 7, 2010
Final Report and Recommendations due July 16, 2010

Subcommittee on HIE Privacy, Security and Patient Consent
Glenn Trowbridge - Chair
Peggy Brown
Valerie Rosalin
Marena Works
Rebecca Gasca (ACLU Nevada)
Ernie McKinley (UMC)
Theresa Presley (DHHS)

Objective: Recommend a statewide HIE policy framework that takes the following privacy issues into serious consideration:

- Recognizes that individuals own their health data,
- Gives individuals control over who can access their electronic health records,
- Gives individuals the right to opt-in and/or opt-out of electronic health systems,
- Gives individuals the right to segment sensitive information,
- Requires audit trails of every disclosure of an individual's health information,
- Requires that individuals be notified when their health information is accessed and by whom,
- Requires that individuals be notified of suspected or actual privacy breaches within a reasonable length of time,
- Provides meaningful penalties and enforcement for privacy violations,
- Requires that health information disclosed for one purpose may not be used for another purpose without informed consent,
- Ensures that individuals cannot be compelled to share electronic health records to obtain employment, insurance, credit, or admission to schools,
- Denies employers access to employees' medical records, and
- Preserves and permits stronger privacy protections in the NRS.

Interim Progress Report due May 7, 2010
Final Report and Recommendations due July 16, 2010

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NEVADA
HEALTH INFORMATION TECHNOLOGY
BLUE RIBBON TASK FORCE

DR. RAYMOND RAWSON, CHAIRMAN

REPORT TO
GOVERNOR JIM GIBBONS

APRIL 30, 2010

This report has been prepared, pursuant to the Executive Order issued by Governor Jim Gibbons, dated September 11, 2009, establishing the Nevada Health Information Technology (HIT) Blue Ribbon Task Force. The order stipulates "that the Task Force shall submit preliminary recommendations to the Governor's Office no later than April 30, 2010 regarding revisions to state laws and regulations that impede the exchange of health care information or to further protect sensitive personal health information, and to present potential health information technology projects and related funding for inclusion in the Governor's recommended budget for Fiscal Years 2011-2012 and 2012-2013."

ARRA HITECH Act of 2009

On February 17, 2009, the American Recovery and Reinvestment Act of 2009 (ARRA) was signed into law. This statute includes the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act) that sets forth a plan for advancing the meaningful use of health information technology (HIT) to improve quality of care through the adoption of electronic health records (EHRs) and the facilitation of health information exchange (HIE).

As mandated by the HITECH Act, the Office of the National Coordinator for Health Information Technology (ONC) is updating the Federal Health IT Strategic Plan published in June 2008, for the 2008-2012 timeframe. The revised plan will encompass 2011-2015, and, as per the statute, will include specific objectives, milestones, and metrics regarding the electronic exchange and use of health information; the utilization of an electronic health record for each person in the United States by 2014; the incorporation of privacy and security protections for electronic exchange of an individual's individually identifiable health information; and security methods to ensure appropriate authorization and electronic authentication of health information.

HITECH required that federal standards be developed to support EHR adoption and meaningful use requirements. CMS and ONC did not issue proposed regulations on the definition of meaningful use and the initial set of standards, implementation specifications, and certification criteria for EHR/EMR technology until December 30, 2009. Public comment was taken until March 15, 2010, and final regulations are now pending.

Status of the Nevada HIT Blue Ribbon Task Force

Since its inception, the Task Force has met five times, and monthly meetings are scheduled during the remainder of the calendar year. Bylaws were adopted, and all meetings are held in accordance with Nevada Open Meeting Law. Task Force meetings are held at two locations, connected via videoconferencing. As often as possible, the meetings are also broadcast live over the Internet, for maximum transparency. The Department of Health and Human Services (DHHS) maintains the HIT Web site (http://dhhs.nv.gov/HIT.htm), which includes information regarding federal HIT/HIE initiatives, Nevada HIE efforts, and the HIT Task Force meetings and activities. It is linked to the Nevada ARRA Web site, and the Nevada ARRA Director receives all meeting agendas and materials.

On October 16, 2009, DHHS submitted an application to ONC for a funding award under the ARRA State HIE Cooperative Agreement Program, and award announcements were expected by mid-January 2010. While waiting for the award and more clearly defined requirements, the Task Force reviewed HIE governance and infrastructure options, lessons learned by other states, and privacy and security concerns. It also met with the Chairman of the Nevada Broadband Task Force to better coordinate efforts, as broadband connectivity is an enabling technology for EHR adoption, meaningful use and HIE.

HITECH State HIE Cooperative Agreement

On February 12, 2010, DHHS received notice that it was awarded a four-year ARRA HITECH State HIE Cooperative Agreement in the amount of $6,133, 426. The award is to be used for the establishment of a basic statewide infrastructure which permits intra-state, interstate and nationwide HIE, and also supports the adoption of EHRs and the accompanying meaningful use requirements. HIE is required for certain providers and hospitals to be eligible for the EHR meaningful use incentives being offered by the Centers for Medicare and Medicaid Services (CMS).

The first phase of the HIE Cooperative Agreement is the development and submission of a state HIT Strategic Plan and HIE Operational Plan. These are due to the Office of the National Coordinator for Health Information Technology (ONC) by August 31, 2010. This planning process requires an environmental scan for determining HIE readiness and adoption across all health care providers in the state, as well as an inventory of the legal framework for facilitating HIE.

Nevada Medicaid must also develop similar plans and engage in comparable planning activities, for which it has received ARRA HITECH funding. HITECH does require that Nevada Medicaid's plans be coordinated and integrated with those of the HIE Cooperative Agreement. ONC and CNS are allowing certain shared activities, and DHHS and Nevada Medicaid expect to pool resources whenever possible, to maximize the return on investment of the ARRA HITECH funding. The first such project is the environmental scan, which will ensure consistency of the resulting data for the planning process. Doing it jointly, using the same vendor, is a cost-effective and an efficient way for both agencies to support and integrate their HIT strategic plan requirements.

During the Task Force meeting on April 9, 2010, five HIE Planning Subcommittees were appointed and tasked to assist DHHS with the development of the strategic plan and operational plan. Each 7-member Subcommittee is chaired by a Task Force member, has at least 3 Task Force members, and includes non-Task Force members to broaden stakeholder participation. Nevada Medicaid, represented on both the Task Force and three of the Subcommittees, expects to utilize the same information and subject matter expertise in developing its plans, to ensure coordination and consistency between the efforts.

Preliminary Recommendations

The funding announcement of the State HIE Cooperative Agreement, which was delayed approximately one month, included new and unexpected requirements not anticipated. Several of these requirements will have a direct impact on the state legislation necessary to enable health information exchange, facilitate EHR adoption, and protect personal health information. The same is true for the final regulations detailing meaningful use standards. These regulations are unknown at this time, with no estimation as to when they will be released, and will need to be cross-walked with state laws, so that gaps may be identified. Finally, addressing the issue of patient consent is critical to successful HIE and EHR meaningful use, and public workshops may be necessary to garner feedback from Nevada residents.

There are four related variables that may impact HIE legal and policy issues, and DHHS is monitoring them. The first is the previously mentioned revision of the Federal Health IT Strategic Plan. There could be additional requirements that would necessitate state leglislation.

While personal health information (PHI) contained in EHRs is protected under HIPAA laws and regulations, that same information, if contained in Personal Health Records (PHRs), is not. PHRs, such as those offered by Google™ health or Microsoft® HealthVault™, fall under the jurisdiction of the Federal Trade Commission (FTC). Because of recent privacy complaints and concerns raised by PHR users and the advent of HIE, the FTC is now reviewing the protection of PHI contained within PHRs. However, there is no indication of when the FTC will render a decision or what the potential outcome might be.

The interim regulations for standards for health information security being developed by the U.S. Department of Commerce's National Institute of Standards and Technology (NIST) are not expected until late summer of this year. CMS is working with NIST to ensure related HIPAA compliance with the HITECH Act, and the use of mobile devices for remote data access is also being addressed.

The fourth variable is broadband connectivity for health care providers and hospitals statewide Under the jurisdiction of the Federal Communications Commission (FCC), the National Broadband Plan is following the previously mentioned revision of the Federal Health IT Strategic Plan. The FCC is incorporating the use of wireless devices and applications in health care as part of the broadband plan, and working to remove the barriers created by HIT gaps that are slowing broadband acceleration.

The results of the legal inventory, required by the HIE Cooperative Agreement, will be necessary to determine what specific revisions to state laws and regulations will be required. However, at this time, the Task Force is able to recommend the following Bill Draft Requests, and more definitive recommendations will be made to Governor Gibbons and his staff, no later than August 23, 2010.

1). Health Information Exchange

BDR: Establishes provisions regarding Health Information Exchange.
BDR: Establishes provisions regarding health record repositories and banks.
BDR: Creates the Electronic Health Records Act; authorizes the creation, maintenance and use of electronic health records.

2). Protection of Personal Health Information

BDR: Establishes provisions relating to electronic health records; clarifies individual rights with respect to the disclosure of information contained in electronic medical records; clarifies the protection of privacy of electronic medical records.

3). Potential HIT Projects and Related Funding

There are no recommendations at this time. The HIE governance structure is expected to be a public-private partnership, with an independent funding mechanism.